IV. Instructions for the Completion of the Support Plan

Update 4/22/2009

General Instructions

The *Support Plan* will be used for people who receive SCDDSN sponsored Level I Service Coordination Services. **The Support Plan format may not be expanded, reduced or changed. The Support Plan is generated from the Service Coordination Annual Assessment information entered in the Consumer Assessment and Planning (CAP) module of SCDDSN's Consumer Data Support System (CDSS). Therefore, the Service Coordination Annual Assessment must be completed on CAP prior to the development of the Support Plan.**

For those receiving Level I Service Coordination, a *Support Plan* must be completed:

- By the 45th calendar day following the determination of eligibility for SCDDSN services
- Within 365 calendar days of the last *Support Plan*
- By the 45th day of being transferred from Level II Service Coordination
- By the 45th day of being transferred from Early Intervention
- Before MR/RD Waiver or HASCI Waiver Services are authorized/provided.

The Service Coordinator is responsible for completing the *Support Plan* and must do so based on the information gleaned from the most recent *SCDDSN Service Coordination Annual Assessment* and with input from the person and/or his/her legal guardian. Each person/legal guardian must be offered the opportunity to meet with the Service Coordinator face-to-face for the purpose of completing the *Support Plan.* If desired, the person/legal guardian may request that others of his/her choosing be invited to this meeting. Meetings should be held at times and locations that are reasonable (within the county for which the person resides and/or the county where the chosen Service Coordination provider is contracted to provide service) sand convenient for all parties. Choice of a face-to-face Plan meeting and, if applicable, meeting participants , date and time of the meeting, and reasonable location for the meeting will be documented in the service notes. Regardless of the meeting, the Plan must be completed by the established timeframes. A completed, signed, and dated Plan must be developed and implemented every 365 days prior to expiration of the current Plan. No services can be authorized or provided in the absence of a current plan. Services provided in the absence of a current, valid Plan cannot be reimbursed by Medicaid.

Instructions

Include identifying information as indicated by the form. If a plan meeting is not held, the date the *Support Plan* is completed by the Service Coordinator is the "Plan Date", and it is this date that will entered into the CAP module of CDSS. If a meeting is held, the "Plan Date" will be the date the meeting is held as indicated in Section E "Meeting Attendees", and it is this date that will be entered into the CAP module of CDSS. In either case, a service note should be written to correspond to the plan implementation

date. The CAP module allows entering of the plan date once all components of the Support Plan are complete on the CAP module of CDSS. Implementation is expected as soon as the plan is completed, which is the date on the "Plan Date" line that is printed by the data entered in the CAP system.

The Service Coordinator who authors the Plan must sign the plan. This is required and is based on a State Plan Medicaid requirement. It is **not** required that the plan be signed by an assigned Service Coordinator who did not author the plan. After the plan is complete on CDSS, the Service Coordinator will print the *Support Plan*, sign the *Support Plan* on page one, and file the *Support Plan* in the person's file.

The service coordination paper file is considered to be the legal document for reflecting service coordination activity. Therefore, it is required to print the initial annual plan from the CAP module of CDSS and any updates/changes made to the plan for the file.
(NOTE: When printing updates to plans for the file, it is not necessary to print the entire planning document each time a change is made. The Service Coordinator can use the "select" option on his/her computer to select only the changed portions of the plan made in the CAP module of CDSS for printing.. It is the Service Coordinator's responsibility in making sure that plans and all changes to the plan made in the CAP module of CDSS is printed for the file when made or within 72 hours from when completed)

General Instructions for Each Area of the *Support Plan*

A. Service Coordination

Indicate the level of service coordination during the time of planning in section A**.**
Level I Service Coordination should be provided when someone::
1. is being determined eligible for DDSN services. (If this person's eligibility determination process has been ongoing for more than 6 months, this question may be answered "no").
2. has identified needs that will require the active and ongoing interventions of a Service Coordinator or Early Interventionist to address. Such interventions may be required due to the person's need for intensive treatment or services, parent/caregiver with limited skills or with a disability who is unable to provide adequate care/supervision of services and needs, the person's undiagnosed condition requiring further evaluation, the person's current or recent involvement in a volatile or possibly abusive, neglectful, or dangerous situation, etc.
3. is in a critical situation (i.e., his/her name is on DDSN critical waiting list).
4. is currently enrolled in the MR/RD, HASCI , PDD or Community Supports Waiver.
5. lives in an alternative placement or a DDSN supported placement other than an ICF/MR.
6. is being concurrently served by DJJ.
7. has medical (including genetic) conditions that require consistent, coordinated care by general or specialty physicians, therapists, and other allied health professionals and needs the active and ongoing interventions of a Service Coordinator regarding those services.
8. is currently experiencing health risk indicators such as uncontrolled high blood

pressure or unmanaged diabetes and their primary care physician is not managing care.
9. has expressed health or safety concerns that neither they nor others have been able to resolve, that they appear not to have recognized or are not addressing or refusing to address.
10. is engaging in behaviors with serious health, safety, or legal consequences.
11. is a threat to the health and safety of others.
12. is experiencing circumstances that are a threat to his/her current living situation (such as behavioral issues or lack of supervision), or that threaten the continuation of care in the near future by the primary caregiver (such as health or aging issues).
13. NOTE: In the event of an adverse report, DDSN may require Level I Service Coordination for persons residing in non-board operated CRCFs or nursing homes.

Indicate the person's service coordination status by checking the appropriate response. A statement is included that describes the reason Service Coordination services are warranted. Throughout the year, these services, when needed, must be provided by the Service Coordinator. If not needed, a change in status may be considered. Unless otherwise indicated, at a minimum, the monitoring requirements outlined in the Service Coordination Standards and MR/RD or HASCI Waiver Manual must be met.

The need for contact in excess of the minimum requirements must be considered at least annually and, if additional contact is needed, the need must be included in this section of the Plan. Additional contact may mean:

1. an increase in the frequency of contact (e.g. contact more frequently than quarterly for some or all services/supports),
2. an increase in the intensity of contact (e.g., face-to-face contact at regular intervals or face-to face contact beyond the required one face-to-face every 365 days)
3. or a combination of increased frequency and intensity.

When considering the need for additional contact, consider if circumstances such as, but not limited to, the following exist:

- The person does not effectively communicate problems or concerns to others. (Does the person make needs known verbally or through sign language? Can the person indicate such things as how he or she got a bruise or how his/her money was spent?)
- The person is physically dependent on others for basic care. (Does he/she have any capacity to physically protect him/herself?)
- The person engages in behaviors that are mentally and physically challenging for caregivers. (e.g., hitting, spitting, kicking, etc.; name calling, taunting, cursing, etc.; extreme uncooperativeness; etc.)
- The person does not have regular contact with family or friends who are not paid agency employees. (If family and friends are available, do they assist the person in decision-making or advocate on his/her behalf and in his/her best interest?)

These circumstances may indicate an increased vulnerability and, therefore, may indicate a need for increased contact. If increased contact is needed, indicate why it is needed and how the contacts will be increased.

B. Compliance Officer Information

Enter the name and phone number of the Service Coordination Agency's Compliance Officer as required by SCDDSN policy 700-02-DD.

C. Emergency Planning

Describe the "back-up" plan and plan for natural disasters. It is <u>not</u> acceptable to assume that parents/family/responsible parties have planned for the person.

Emergency Plans must include the following components on all Plans:

a. <u>For people residing in SCDDSN sponsored residential settings</u>: Documentation on the Plan will include, but not limited to,:

1. a statement regarding the location of the detailed emergency disaster plan

b. <u>For people in all other settings (including non-DDSN sponsored residential settings):</u>

Documentation on the Plan will include, but not limited to:

1. what plans have been made for an emergency/natural disaster or loss of primary caregiver
2. what transportation services/supports will be used and/or how the person will be transported
3. where the person will evacuate to if an evacuation is required

D. Needs and Services

a. Need: (DELETE -Indicate what the person needs.) This information will automatically come from the *Assessment Worksheet* data in the CAP module after the needs are prioritized. Needs that are carried over from the worksheet to the plan should be manipulated into one clear needs statement/phrase. If known, indicate if the need is related to one of the person's personal goals and, if so, indicate how it relates. For example, if a person desires to work in a retail store one day, then prevocational services may have goals and objectives that relate to duties in a retail store.

b. Service /Intervention to Address Need: Indicate or choose from the drop-down choices on the CAP module the specific service /intervention that will be authorized/implemented in response to the need. If the service is funded by a DDSN operated HCBWaiver, the appropriate Waiver service name must be chosen. If the appropriate service name is not listed, the Service Coordinator can choose the "Other" option and type this information in the provided space.

c. Date the Service /Intervention Included in This Plan: The date the Service /Intervention are included in this Plan is pre-filled by the CDSS to be the date the Service Coordinator is actually keying the information into the system. If the service was authorized/implemented during the previous plan year, the "Plan Date" from page 1 of this document is printed here by the CAP system. If the Service /Intervention is being included for the first time during planning, the "Plan Date" is the date that is printed here by the CAP system. If the Service /Intervention is being added to an existing Plan, the date the need is being added is the date printed here by the CAP system.

d. Funding Source: Choose the funding source from the drop-down box for the Service/Intervention that was indicated as explained in c. above (i.e., choose the funds which are used to pay for the Service /Intervention). Examples: SCDDSN funding, HASCI Waiver, MR/RD Waiver, Medicaid State Plan, Private Insurance, Family Support Funds, etc.

e. Amount/Frequency/Duration: Enter the amount, frequency, and duration of the service into this box. The amount should reflect how much service someone will receive. For all services, a "unit" is specified. For Day Habilitation, Prevocational service, Facility-Based Rehabilitation Support, Residential Habilitation (except SLPI), and daily Respite, a unit typically equals 1 day of service. For Supported Employment, SLP I Residential Habilitation, hourly Respite, etc. a unit equals 1 hour of service. For Assistive Technology, the number of units (how much of the service) and the dollar amount will be identified. Refer to the particular DSSN operated Home and Community Based Waiver manual to determine specific Waiver service units. For Family Support, a dollar amount may be entered rather than a unit. Indicate how often (frequency) the person will receive the service and how long it will last (duration). For example "weekly" would be considered a frequency and "for 3 months" would be considered duration. If the service is on-going, meaning that the service will likely continue indefinitely, enter "For the duration of the plan" or enter a timeframe that is not beyond the date of expiration of the plan (i.e., 365 days from plan date).

f. Provider Type: Indicate the kind/type of provider who will provide the service; NOT the actual name of the provider. Provider type relates to the service. Some examples are, but not limited to, the following:
    1. Respite services can be provided by a foster home, group home, SCDDSN Licensed Respite Caregivers, in SCDDSN Licensed Respite Facilities/Settings, in an ICF/MR, nursing facility, or by a respite provider chosen by the person/family.
    2. Personal Care services or Attendant Care services are provided by Personal Care providers or Attendant Care Providers.
    3. Specialized supplies, medical equipment and assistive technology are provided by a durable medical equipment provider.

4. Individual Rehabilitation Support Services are provided by SCDDSN enrolled Rehabilitation Support Providers.

For DDSN operated Home and Community Based Waiver services, refer to the Waiver Manual that is appropriate for more examples.

g. Service Coordinator's Responsibilities / Person/Guardian's Responsibilities and Timeframe/Projected Completion Date: Indicate each person's responsibilities related to arranging for, participating in the implementation of, and/or communicating about the service and its effectiveness in meeting the need. The intention is to assure that everyone's role is clearly understood and documented along with the timeframe or date by which the responsibility will be completed/ done. For example, the Service Coordinator will be responsible for providing information about the available providers by a specific date while the person will be responsible for selecting a provider and communicating their choice by a specific date.

For those enrolled in the MR/RD or HASCI Waiver, it is required that each participant's plan include all services regardless of the funding source. In particular, State Plan Medicaid services must be included in the Plan prior to their use. In order to assure that services are included, those services that will likely be accessed during the coming year should be included in the Plan. The following exemplifies how this can be done:

<table>
<tr><td colspan="2"># __<u>1</u>__. What does this person need? Routine and emergency medical care and services.

Does this need relate to a personal goal expressed by this person?
☒ Yes ☐ No ☐ Unknown
If known explain how? (Person's name) wants to be healthy as possible.</td></tr>
<tr><td colspan="2">Service / Intervention to address the need:
Physician visits, ER visits, Home Health Services, Durable Medical Equipment, Medical Transportation, Emergency Dental(include only if an adult), Pharmacy(include this only if previously not included; more specifically i.e., those with no routine medications would likely receive Rx for acute illness), Therapy (include only for children under age 21)
Note: Only in this context may multiple services/interventions be included in one section.</td></tr>
<tr><td>Date Service / Intervention was included in this Plan: Date of Plan</td><td>Funding Source for the Service / Intervention: State Plan Medicaid</td></tr>
<tr><td colspan="2">Amount, Frequency and Duration of Service/Intervention:
As needed and/or ordered by physician or specialist.</td></tr>
<tr><td colspan="2">Service/Intervention Provider Type: Medicaid enrolled providers</td></tr>
<tr><td colspan="2">Service Coordinator's Responsibilities related to Service/Intervention and Timeframes/ Expected Completion Dates: Offer choice of physician or health service provider (if not chosen already), monitor service use, and assist with accessing services if needed (for 12</td></tr>
</table>

months).
Person/Legal Guardian's Responsibilities related to Service/Intervention and Timeframes/ Expected Completion Dates: *Choose health care providers, access services, as needed or ordered, contact Service Coordinator for assistance if needed (for 12 months).*

Need/Service/Intervention Change: This section will <u>not</u> be completed at the time of annual planning. Instead, it will be used to document changes to the plan. Changes to the Needs/Intervention section of the plan must be made and entered using the CAP module of CDSS.

i. Indicate the status of the Need - Has it been met or not?
ii. Indicate the kind of change being made to the Service/Intervention. Is it being revised or discontinued?
iii. -If the need was "not met" and the Service/Intervention is being "revised", explain what changes are being made to facilitate meeting the need. Some examples may be, but are not limited to, that "a change of provider type is requested" or the "times for the provision of the service need to be changed".

-If the need was "not met" and the Service/Intervention is being discontinued, explain why (the concern is that an important need still exists without being addressed). Examples of an explanation include, but aren't limited to, "The person no longer wishes to have this need addressed", "There has been a significant life change and this is no longer a priority".

-If a new need is identified during the course of the plan year, the Service Coordinator will document the need and any discussion surrounding the identification of the need in the service notes. The Service Coordinator will also add a new "needs box"/need to the plan using the CAP module of CDSS. The "Date Service/Intervention was included in this Plan" is pre-filled as the date the new need was identified or being added(should correspond to service notes that document discussions related to the need).

E. Plan Attendees

This page is generated by CDSS and will be printed prior to the scheduled plan meeting (if a plan meeting is held). It will be taken to the plan meeting and signed by all who attend the plan meeting. Indicate the date of the meeting and the name of the person for whom services/supports are being planned. During the meeting, all attendees must sign. If no face-to-face meeting is held, this section (page) will not be used.

For MR/RD or HASCI Waiver participants, when State Plan Medicaid services that will likely be accessed during the coming year are included in the Plan in the manner noted in the instructions, those services must be monitored. The following exemplifies how those State Plan Medicaid services may be monitored:

Monitoring and Review

(For use by Service Coordinators, not intended for distribution as part of the Plan unless specifically requested)

Service/ Intervention for Need #__1__

Routine and emergency medical care and services.

Has the service/intervention been provided/implemented?

☐ **Yes** *(Score yes only if one of the listed State Plan services was accessed during the quarter)*

A. If **yes**, did the service / intervention address the need? ☐ Yes ☐ No
If it didn't address the need, why not? ☐ The need changed.
☐ The service was not suitable/ appropriate.
☐ Other: _____

B. If **yes**, was the person/legal guardian satisfied with the service? ☐ Yes ☐ No
If not, why not and what actions have been/will be taken? _____

_____

C. If **yes**, was the person/legal guardian satisfied with the provider? ☐ Yes ☐ No
If not, why not and what actions have been/will be taken? _____

_____

☒ **No** *(Score no if none of the listed State Medicaid plan services were accessed)*

A. If **no,** what prevented the service from being provided? _____

Not needed during the quarter

Is this still occurring? ☒ Yes ☐ No
If so, what actions have been/ will be taken to address the reason it wasn't provided?

Not applicable (N/A)

Comments:

Person (put person's name) continues to need routine medical care and medical care in the event of an emergency.

Information sources used for review: *Person receiving services(put their name) and family(list family member or members' name)*

(Service Coordinator's Signature) *(Date Monitoring Completed)*

_____ _____

Completed by **Date**